



First Choice Primary Care, Inc.

COACHCARE | SERVICE LINE STRATEGY

A HRSA Health Center Program Section 330 grantee serving Macon and Warner Robins in Middle Georgia, from eight clinical sites, two on-site pharmacies and school-based clinics

Remote Care Service Line Performance & Optimization

2026 Strategy Report

A chronic-disease service line for the health center's 3,288 Medicare patients, roughly a third of them dually eligible: remote physiologic monitoring, chronic care management and advanced primary care management, billed under the rules that have paid a health center for those codes individually, on top of the PPS encounter, since October 2025, and staffed by CoachCare

Purpose of this document

Prepared by CoachCare, September 2026, as a discussion document for the leadership of First Choice Primary Care. It brings together the health center's own HRSA record, the Medicare structure of Middle Georgia, the billing rules a health center works under since October 2025, a 24-month Value Analysis for a remote care service line on the Medicare panel, the clinical governance that would run it, the eClinicalWorks integration it lives in, and the access-focused design a First Choice program has to get right.

The argument is direct. First Choice already sees 3,288 Medicare patients, 5,410 of them with high blood pressure and 2,671 with diabetes, a few times a year. Since last October, Medicare pays a health center for the month of care between those visits as its own codes, at national amounts, on top of every visit; on a panel this size that is a seven-figure line the center is not billing today, and the dual-eligible patients make the monthly advanced primary care code worth the most of all. The people to enroll and manage them are ours.

Prepared by CoachCare for discussion with First Choice Primary Care. © 2026 CoachCare.

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Executive Summary

First Choice Primary Care is a HRSA Health Center Program Section 330 grantee serving Macon, in Bibb County, and Warner Robins, in Houston County, across Middle Georgia. Founded in 2007, it has grown to eight clinical sites, two on-site pharmacies and school-based clinics, and opened its newest site in South Macon in January 2025.¹ Its 2025 Uniform Data System report counts 11,503 patients: 3,288 with Medicare as primary payer, 1,048 of those dually eligible, 2,949 aged 65 or older, 2,223 uninsured, 5,410 with hypertension and 2,671 with diabetes, and 94.9% of them at or below the federal poverty guideline.² Over five reporting years it lifted blood-pressure control from 56.85% to 62.61% and cut diabetes poor control from 29.51% to 24.56%.³

What the record does not yet show is a Medicare revenue line for the month between visits. The health center's telehealth is video-only, and its public materials show **no remote-monitoring, chronic-care-management or advanced-primary-care billing program and no care-management role on the careers page**.⁴ The 5,410 patients with hypertension and 2,671 with diabetes are seen a few times a year; this is the between-visit care the new rules now pay for.

Macon and Bibb County are a high Medicare-Advantage market, near 61%, so most of the 3,288 Medicare patients are Medicare Advantage lives.⁵ These figures use the national amounts Medicare pays a health center for these codes. Medicare Advantage plans, which cover most of the Medicare panel in this market, reimburse the care-management and remote-monitoring families at a floor at least equal to the Medicare amount; individual plan contracts set their own terms.

The observation this report is built on

First Choice already sees 3,288 Medicare patients, 5,410 with high blood pressure and 2,671 with diabetes, a few times a year. Since last October, Medicare pays a health center for the month of care between those visits as its own codes, at national amounts, on top of every visit; on a panel this size that is a seven-figure line the center is not billing today, and the dual-eligible patients make the monthly advanced primary care code worth the most of all. The people to enroll and manage them are ours.

G0511, the bundled code health centers used for care management, was retired on September 30, 2025. From October 1, 2025 a health center bills chronic care management, remote physiologic monitoring and advanced primary care management as individual codes at national non-facility Physician Fee Schedule amounts, in addition to the PPS encounter.⁶ The short-window RPM codes new for 2026 (99445, 99470) fit post-discharge monitoring exactly.

¹ HRSA Health Center Program: First Choice Primary Care, a Section 330 grantee (Community Health Center and Health Care for the Homeless funding streams), founded 2007. The health center's own site: eight clinical sites across Macon (Bibb County) and Warner Robins (Houston County), two on-site pharmacies, school-based clinics, and a South Macon site opened January 2025.

² HRSA Uniform Data System, First Choice Primary Care, reporting year 2025: total patients 11,503; Medicare 3,288 (28.6%); dually eligible 1,048; aged 65 and over 2,949; uninsured 2,223 (19.3%); hypertension 5,410; diabetes 2,671; 94.9% at or below 100% of the federal poverty guideline.

³ HRSA UDS 2021 and 2025 clinical quality measures: controlling high blood pressure 56.85% (2021) to 62.61% (2025); diabetes A1c above 9% or untested 29.51% to 24.56%; statin therapy for cardiovascular prevention 58.19% to 79.21%.

⁴ The health center's website and careers page, retrieved September 2026: telehealth is a video-visit service; chronic-disease management is described as a clinical service line, with no connected-device fleet, no care-management team and no remote-monitoring or care-coordinator role posted.

⁵ CMS Medicare Advantage State/County Penetration: Bibb County Medicare Advantage penetration near 61% (secondary source; confirm against CMS county penetration and a payer reconciliation of the health center's own panel).

⁶ CY2025 Physician Fee Schedule Final Rule: rural health clinics and Federally Qualified Health Centers report the individual CPT and HCPCS codes for care management in place of G0511, paid at national non-facility Physician Fee Schedule amounts in addition to the PPS encounter; G0511 retired September 30, 2025 after a transition period; advanced primary care management adopted on the same basis. CY2026 Final Rule for 2026 dates of service.

What the Value Analysis returns

The forecast prices a service line for the health center's own Medicare panel, 3,288 patients as reported to HRSA for 2025, Original Medicare and Medicare Advantage together, referred by the twenty adult-medicine clinicians on the staff, and delivered by CoachCare under the health center's clinical direction, priced at the national amounts a health center is paid for these codes.⁷

	Year 1	Year 2	24 months
Net reimbursement	\$829,992	\$1,606,649	\$2,436,642
CoachCare fees	\$485,053	\$918,640	\$1,403,693
Net to the health center	\$344,939	\$688,009	\$1,032,948
Margin to the health center	41.56%	42.82%	42.39%

CoachCare Value Analysis. CY2026 national non-facility Physician Fee Schedule amounts, the rail a health center bills care-management codes on. 3,288 Medicare patients in scope; RPM + CCM + APCM. Margin is net to the health center divided by net reimbursement.

1. **This is a seven-figure service line, and it is built honestly.** Over 24 months it produces \$2,436,642 of net reimbursement and \$1,032,948 net to the health center, a 42.39% margin, on a 3,288-patient Medicare panel. It is additive: every care-management dollar lands on top of the PPS encounter the health center already bills. At M24 the program holds 1,488 active program enrollments, which are services rather than patients, across 970 unique patients.
2. **The binding constraint in year one is enrollment pace, not the eligibility ceiling.** The panel is large enough that the program is still filling through the first year: advanced primary care management reaches its ceiling in M6, chronic care management in M10, and remote monitoring not until M16. The forecast asks the clinicians for a steady referral flow, not a standing start.
3. **The program funds itself from the second month.** Month 1 nets -\$4,691 to the health center, because implementation lands before enrollment revenue does. The first positive month is M2, at \$5,307. From M17, once every program is at ceiling, the line runs at \$135,478 in monthly net reimbursement and \$57,944 net to the health center.
4. **The dual-eligible mix is the wedge under APCM.** 1,048 of the 3,288 Medicare patients, 31.9%, are dually eligible. Advanced primary care management pays its highest tier, G0558 at \$117.24 a month, for Qualified Medicare Beneficiaries, which makes G0558 the best-paying monthly code on the page. APCM is one of three arms at \$419,870 over 24 months; remote monitoring is the largest at \$1,182,356.
5. **Nobody is hired.** CoachCare delivers 16,444 hours of care-team work over 24 months, about 7.9 full-time-equivalent years, including an on-site enrollment specialist carried at CoachCare's expense, for a health center that opened its newest site with one physician and one nurse practitioner and is still adding capacity. No capital outlay and no new requisition.
6. **The growth is in the panel, and the report says where.** Most of the 3,288 are Medicare Advantage lives. The conservative floor, counting only traditional Medicare, is \$1,126,144 of 24-month net reimbursement and \$471,036 net to the health center, on roughly 1,282 patients; the full-panel figure assumes Medicare Advantage parity across the book. Reconciling the traditional-versus-Advantage split of the panel, and which plans the duals carry, is discovery item one.
7. **The clinical return is concrete.** The forecast projects 80.7 avoided hospitalizations over 24 months, roughly \$1,210,500 at \$15,000 per admission, from 127,137 device readings worked through one escalation protocol, with the discharge from a Middle Georgia hospital as one trigger.

⁷ CoachCare Value Analysis for First Choice Primary Care, 2026. Basis: CY2026 national non-facility Physician Fee Schedule amounts; 3,288 Medicare patients in scope; 20 referring clinicians; RPM, CCM and APCM.

1. The Health Center Today

1.1 Two counties, eight sites, one growing safety net

First Choice Primary Care opened in 2007 and is a HRSA Health Center Program Section 330 grantee, funded under the Community Health Center and Health Care for the Homeless streams and enrolled with Medicare as a Federally Qualified Health Center.⁸ It runs eight clinical sites across Macon and Warner Robins, two on-site pharmacies, and school-based clinics, and it opened a new South Macon site in January 2025. The patient base is a safety-net population: 94.9% of patients are at or below the federal poverty guideline, and one in five carries no insurance. The health center already runs a patient-centered medical home care-team model, so the panel and the care team a service line needs are in place.

UDS 2025	Count	What it means for the service line
Total patients	11,503	Medical, dental, behavioral and enabling services across eight sites
Medicare patients	3,288 (28.6%)	The panel this forecast runs on; Medicare Advantage and the 1,048 duals are inside it
Aged 65 and over	2,949 (25.6%)	A conservative alternative scoping; the Medicare panel is larger because it includes under-65 Medicare
Dually eligible	1,048	31.9% of the Medicare panel; the population the APCM top tier was written for
Uninsured	2,223 (19.3%)	Outside the Medicare forecast; every billable Medicare patient is worth more to a safety-net budget
Hypertension	5,410	The RPM cohort; blood-pressure control 62.61%
Diabetes	2,671	Glucose monitoring; poor control down to 24.56%
At or below the poverty guideline	94.9%	The access case for cellular devices and a monthly documented touch

HRSA Uniform Data System, First Choice Primary Care, reporting year 2025.

1.2 Quality the record can verify

The five-year quality trend is the earned compliment. Blood-pressure control rose from 56.85% to 62.61%, and it is the measure a monitoring program moves most directly. Diabetes poor control, the share of diabetic patients with an A1c above 9% or untested, fell from 29.51% to 24.56%. Statin therapy for cardiovascular prevention went from 58.19% to 79.21%.⁹ A health center that has already moved these numbers on a panel that is 95% at or below the poverty line has shown it can change a measure; the between-visit gap is what remains.

Clinical quality measure, UDS	2021	2025
Controlling high blood pressure	56.85%	62.61%
Diabetes: A1c above 9% or untested (lower is better)	29.51%	24.56%
Statin therapy for cardiovascular prevention	58.19%	79.21%

HRSA Uniform Data System clinical quality measures, 2021 and 2025.

⁸ HRSA Health Center Program Section 330 grantee record (Community Health Center and Health Care for the Homeless funding streams); CMS Medicare-certified Federally Qualified Health Center enrollment; the health center's organization National Provider Identifier.

⁹ HRSA UDS clinical quality measures, reporting years 2021 and 2025: controlling high blood pressure 56.85% to 62.61%; diabetes A1c above 9% or untested 29.51% to 24.56%; statin therapy for cardiovascular prevention 58.19% to 79.21%.

1.3 The gap: the month between visits

Between-visit chronic care has no Medicare revenue line here yet, and it is a structural observation rather than a criticism. The health center's telehealth is a video-visit service; its public materials describe chronic-disease management as a clinical service line, not a billing-grade program, and show no connected-device fleet, no care-management team, and no remote-monitoring or care-coordinator role on the careers page.¹⁰ The result is that the recurring, per-patient revenue the new rules attach to the month between visits is, at First Choice today, unbilled.

The health center has built the layer a program sits on. It runs enabling services, transportation support and marketplace enrollment help for a 95%-below-poverty panel, and it reaches its patients across eight sites and the schools. A monthly documented touch by phone reaches a patient for whom a clinic visit is a half-day and a bus fare, and that is the layer this service line builds on.

2. What Changed: A Health Center Now Bills the Month Between Visits

2.1 G0511 is gone; the individual codes pay on top of the PPS encounter

Federally Qualified Health Centers are paid a prospective payment per qualifying encounter. For years, everything a health center did for chronic patients between those encounters was compressed into one bundled monthly code, G0511, a single flat payment regardless of how many services, minutes or programs a patient carried. That code was retired on September 30, 2025. From October 1, 2025 a health center reports the individual CPT and HCPCS codes, the CCM, RPM and APCM families among them, and Medicare pays each at the **national non-facility Physician Fee Schedule amount, in addition to the PPS encounter**.¹¹

CY2026 also added two codes that matter for a health center whose patients are discharged from the Middle Georgia acute-care hospitals First Choice's patients use: 99445 pays the device-supply month when a patient transmits 2 to 15 days of readings rather than 16 or more, and 99470 pays the first 10 minutes of monthly management time where 20 minutes is not reached. A patient discharged on the 20th of the month used to produce an unbillable partial month; now it bills.¹²

The structural consequence is the point. Between-visit care stops being a flat bundled payment and becomes a per-service revenue line that scales with enrollment and delivered work, on a panel the health center already sees.

2.2 What the codes pay a health center

The Value Analysis is priced at the national amounts a health center is paid for these codes: the CY2026 non-facility Physician Fee Schedule at the national conversion factor with no geographic adjustment. That is the rail a health center bills care-management codes on, and it is the only basis on any page of this report.¹³

Code	What it pays for	Cadence	CY2026 national amount
99453	RPM setup and patient education	One-time	\$21.71

¹⁰ The health center's website and careers page, retrieved September 2026 (see note 4).

¹¹ CY2025 Physician Fee Schedule Final Rule (see note 6): G0511 retired with a transition period through September 30, 2025; from October 1, 2025 the individual codes are the standing requirement for health-center care management; the CY2026 Final Rule adds the APCM behavioral-health add-on codes for health centers effective January 1, 2026.

¹² CY2026 Physician Fee Schedule: 99445 (device supply, 2 to 15 days of readings) and 99470 (remote-monitoring management, first 10 minutes) added for 2026 dates of service. CMS Hospital General Information: the CMS-certified acute-care hospitals in Middle Georgia the health center's patients use, referenced by region only.

¹³ CY2026 Physician Fee Schedule national non-facility amounts: total non-facility relative value units times the national conversion factor, with every geographic practice cost index at 1.000. Health centers bill the care-management codes at the national amount regardless of the locality their ZIP code falls in.

Code	What it pays for	Cadence	CY2026 national amount
99454	Device supply, 16–30 days of readings	Monthly	\$52.11
99445	Device supply, 2–15 days of readings (new 2026)	Monthly	\$52.11
99457	RPM management, first 20 minutes	Monthly	\$51.77
99470	RPM management, first 10 minutes (new 2026)	Monthly	\$26.05
99458	RPM management, each additional 20 minutes	Monthly	\$41.42
99490	CCM, first 20 minutes of clinical staff time	Monthly	\$66.13
99439	CCM, each additional 20 minutes	Monthly	\$50.44
G0556	APCM, level 1: one chronic condition	Monthly	\$16.37
G0557	APCM, level 2: two or more chronic conditions	Monthly	\$53.78
G0558	APCM, level 3: Qualified Medicare Beneficiary	Monthly	\$117.24
99495	Transitional care management, moderate complexity	Per discharge	\$220.11 (named, not in the forecast)
99496	Transitional care management, high complexity	Per discharge	\$298.60 (named, not in the forecast)
99484	Behavioral health integration, first 20 minutes	Monthly	\$57.45 (named, not in the forecast)

CY2026 national non-facility Physician Fee Schedule amounts, the Value Analysis basis. The APCM tier blend in the forecast (15% level 1, 64% level 2, 21% level 3) yields \$61.49 per patient-month, with the level-3 weight set to the Qualified Medicare Beneficiary share implied by 1,048 duals in a panel of 3,288.

These are the national amounts Medicare pays a health center. Medicare Advantage plans, which cover most of the Medicare panel in this market, reimburse the care-management and remote-monitoring families at a floor at least equal to the Medicare amount; individual plan contracts set their own terms. In a market that is near 61% Medicare Advantage, that contract check is the single largest thing to confirm, and it is discovery item one in Section 12.

2.3 The work the change creates, and who carries it

Individual-code billing pays more and asks more. Each code carries its own eligibility test, consent, time capture and documentation standard, and the claim volume is real: this forecast generates 38,044 claims over 24 months. In the operating model of Section 10, CoachCare carries the load: enrollment, device logistics, monitoring documentation and billing-ready claim generation inside eClinicalWorks. The health center's own billing team files the FQHC claims with the care-management codes, and the clinicians keep the clinical decisions.

One structural note on the other payers, because the deal design has to respect it. The Medicare forecast on these pages does not include a Medicaid dollar; Georgia Medicaid coverage of remote monitoring is a separate question, sized on its own if and when the health center wants it, never folded into the Medicare figures. Medicare is the only rail in this forecast.

3. The Service Line: RPM, CCM and APCM on the Medicare Panel

3.1 The clinical and billing stack

Three programs, one infrastructure. Remote physiologic monitoring supplies the daily signal; chronic care management and advanced primary care management supply the monthly coordination wrapper. Enrollment, devices, monitoring, escalation, documentation and claims run on the same CoachCare

engine for all three. Principal care management is off: a primary-care panel bills CCM or APCM, not the single-condition specialist code.

Program	Who qualifies	What it is	Billing
RPM	2,137 of the 3,288 Medicare patients (65%): hypertension, diabetes, heart failure, COPD	Cellular-connected devices (blood-pressure cuff, glucose meter, scale, pulse oximeter); readings monitored against clinical thresholds; monthly management time	99453 setup; 99454/99445 supply; 99457/99470/99458 management
CCM	1,315 (40%): two or more chronic conditions expected to last twelve months or more	Monthly non-face-to-face coordination: comprehensive care plan, medication reconciliation, referrals, outreach	99490 + 99439
APCM	1,151 (35%): ongoing primary-care relationship; level set by condition count and Qualified Medicare Beneficiary status	Monthly bundle of thirteen practice-capability elements; no minute tracking	G0556 / G0557 / G0558
TCM	Any inpatient discharge home from a Middle Georgia hospital	Contact within two business days, medication reconciliation, a face-to-face visit within 7 or 14 days	99495 / 99496, named and not in the forecast

Eligible-pool counts from the Value Analysis eligibility model; pools overlap, billing does not (see the coordination rule below).

One coordination rule, set at enrollment

APCM and CCM never bill for the same patient in the same month; a patient carries one care-management wrapper, not two. RPM stacks with either. A transitional care episode runs for 30 days after a discharge and does not overlap APCM for that patient in that month. The enrollment workflow assigns each patient a wrapper (CCM or APCM) plus RPM where clinically indicated, so the code families never collide on a claim.

3.2 A third of the panel is dually eligible: why APCM pays more here

Advanced primary care management is a monthly bundle with three tiers, and the tier is set by the patient, not the minutes. Level 1 (G0556, \$16.37) covers one chronic condition; level 2 (G0557, \$53.78) covers two or more; level 3 (G0558, \$117.24) applies to a Qualified Medicare Beneficiary with two or more. In most panels the level-3 tier is a small minority. Here, 1,048 of 3,288 Medicare patients, 31.9%, are dually eligible, and roughly two-thirds of Georgia's duals hold Qualified Medicare Beneficiary status.¹⁴ The forecast weights the tiers 15% level 1, 64% level 2 and 21% level 3, which blends to \$61.49 per patient-month. That makes G0558 the single best-paying monthly code on the page. It is not the whole story: APCM is one of three arms at \$419,870 against remote monitoring's \$1,182,356, and the dual tier is its engine, not the program's.

The service line pays the health center three ways. First, additive revenue: every care-management dollar lands on top of the PPS encounter, not inside it. Second, the UDS measures the health center reports each year, blood-pressure control at 62.61% and diabetes poor control at 24.56%, move on continuous readings and a monthly documented touch. Third, avoided admissions: a patient whose fluid weight climbs for four days is treated by phone and in clinic, not admitted three weeks later. That is where the forecast's 80.7 avoided hospitalizations come from.

¹⁴ HRSA UDS 2025: 1,048 dually eligible of 3,288 Medicare patients (31.9%). CMS Advanced Primary Care Management materials: G0558 applies to a Qualified Medicare Beneficiary with two or more chronic conditions. CoachCare Value Analysis APCM tier weights 15% / 64% / 21%, blending to \$61.49 per patient-month at the national amounts; the level-3 weight is set from the 31.9% dual share and the roughly two-thirds Qualified Medicare Beneficiary share of Georgia duals.

3.3 The Medicare panel it runs on

The forecast is built on **3,288 Medicare patients**, the health center's own count as reported to HRSA for 2025, Original Medicare and Medicare Advantage together; Medicare Advantage and the 1,048 duals are already inside it, with no gross-up. From that panel the eligibility model carves the program pools: 2,137 patients RPM-eligible (65%), 1,315 CCM-eligible (40%), 1,151 APCM-eligible (35%). The pools overlap; the coordination rule keeps the billing disjoint.¹⁵

The question that moves every ceiling here is not the size of the Medicare panel, which the health center reports, but its split between traditional Medicare and Medicare Advantage. In a market near 61% Advantage, most of the 3,288 are Advantage lives. The figures use the national amounts a health center is paid, and Medicare Advantage plans, which cover most of the Medicare panel in this market, reimburse the care-management and remote-monitoring families at a floor at least equal to the Medicare amount; individual plan contracts set their own terms. The traditional-versus-Advantage reconciliation, and which plans the duals carry, is the first question of the working session in Section 12.

3.4 Transitional care at the hospital discharge, named and not in the forecast

Each discharge home from a Middle Georgia acute-care hospital opens a transitional care management episode: an interactive contact within two business days, medication reconciliation, and a face-to-face visit within 14 days (99495, \$220.11 at the national amount) or 7 days (99496, \$298.60).¹⁶ TCM is on the recommended stack for that reason, and it carries no dollars anywhere in this forecast: the health center's discharge volume, the share of discharges that come home to a health-center patient, and visit-scheduling capacity are all discovery items. What TCM does in the forecast is clinical. A discharge is the highest-yield moment to enroll a patient in monitoring, and the three-touch post-discharge cadence in Section 6.5 runs on the same contact the TCM code requires. It is the discharge-to-monitoring loop, never the revenue base.

3.5 Behavioral health integration: the next arm, named

A health center with in-house behavioral health, a licensed counselor and a psychiatric nurse practitioner on staff, has an obvious fourth program waiting: behavioral health integration, 99484, \$57.45 a month at the national amount for the first 20 minutes of care-manager time under a treating clinician's plan.¹⁷ It is the same infrastructure, the same monthly cadence and the same billing engine, applied to a population the health center already treats. This forecast carries it at zero dollars and names it once, here, as the natural next arm once the three Medicare programs are at ceiling.

3.6 Built the way the codes work: a twenty-clinician bench

First Choice employs roughly twenty-nine medical providers across its sites; this forecast counts a conservative twenty of them as the referring bench, the adult-medicine clinicians, and excludes the behavioral-health providers and the pediatric, school-based and women's-health-only clinicians.¹⁸ Most of the twenty are nurse practitioners and physician assistants, and for this service line that is the right shape. CCM, APCM and RPM are general-supervision code families: qualified clinical staff deliver the monthly work under a billing clinician's overall direction, without that clinician in the room. The referral motion is one step, a clinician flags a qualifying patient in the chart, and the program runs from there. At

¹⁵ HRSA UDS 2025 (see note 2). CoachCare Value Analysis eligibility model: RPM 65%, CCM 40%, APCM 35% of the in-scope panel.

¹⁶ CPT 99495 and 99496 requirements (interactive contact within two business days of discharge; face-to-face visit within 14 or 7 days; moderate or high medical decision-making); CY2026 national non-facility amounts \$220.11 and \$298.60. CMS Hospital General Information: the CMS-certified acute-care hospitals in Middle Georgia the health center's patients use. TCM is carried at zero dollars in every figure in this report.

¹⁷ The health center's behavioral-health service line as described on its site; CPT 99484, CY2026 national non-facility amount \$57.45. BHI is carried at zero dollars in every figure in this report.

¹⁸ The health center's provider roster as described on its site: roughly 29 medical providers across the sites, of whom 20 adult-medicine clinicians are counted as the referring bench; behavioral-health, pediatric, school-based and women's-health-only clinicians are excluded. Most of the 20 are nurse practitioners and physician assistants.

eight referrals per clinician per month the bench fills every program, and Section 11 shows the clinician count moves the timing more than the result, from 14 clinicians to 29.

3.7 Staffing: nobody is hired

CoachCare delivers 16,444 hours of care-team work across the 24 months, about **7.9 full-time-equivalent years**, without the health center hiring anyone. The on-site enrollment specialist is CoachCare's expense, not a program cost. For a health center that opened its newest site with one physician and one nurse practitioner and is still adding capacity, the service line adds working capacity and zero requisitions. The health center's clinicians contribute the two things only they can: the referral flag that starts each enrollment and clinical judgment at the escalation points.

4. Value Analysis: The 24-Month Forecast

4.1 Headline economics

Over 24 months the service line produces **\$2,436,642 in net reimbursement** to First Choice Primary Care. CoachCare's fees total \$1,403,693, including \$61,417 of ancillary items: implementation, the eClinicalWorks integration and telephonic outreach. Net to the health center is **\$1,032,948, a 42.39% margin** on the program, 41.56% in Year 1 and 42.82% in Year 2.¹⁹

The 24-Month Ramp: Pace-Limited in Year One, RPM at Ceiling by Month 16

CoachCare Value Analysis · 3,288 Medicare patients in scope · at M24: 1,488 active enrollments across 970 unique patients

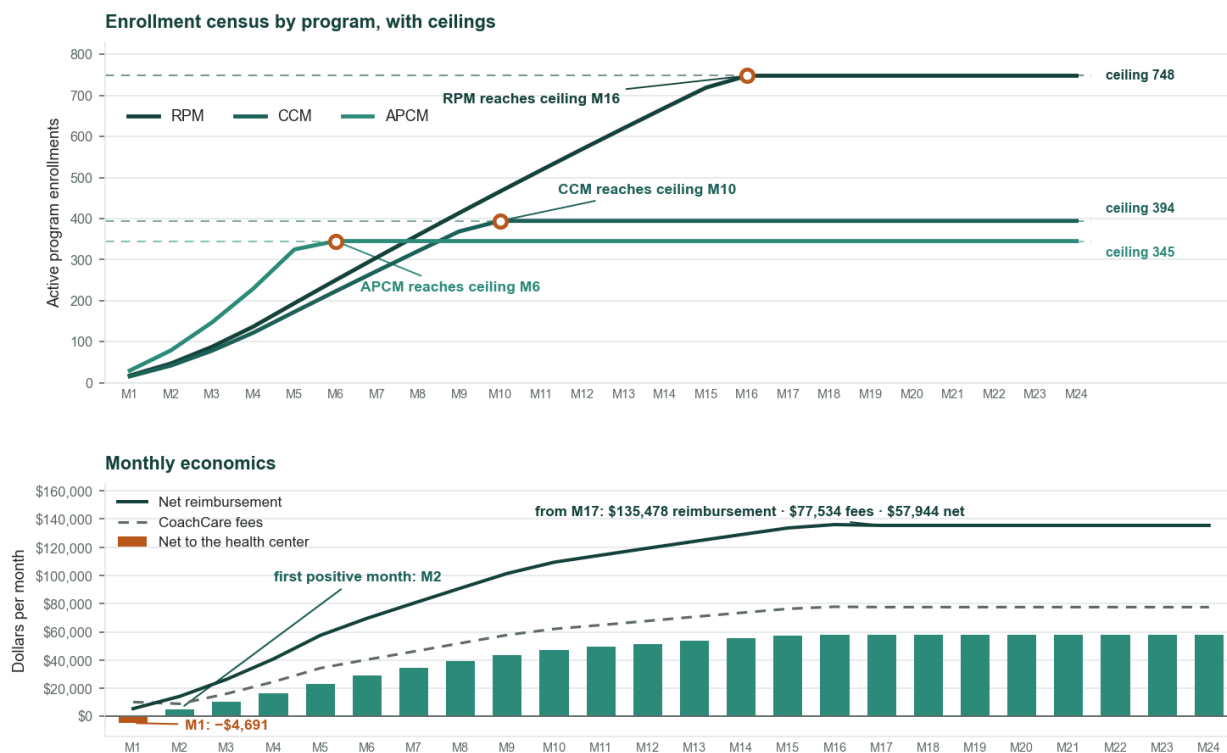


Figure 1. The 24-month ramp: enrollment census by program with ceilings (above) and monthly net reimbursement, CoachCare fees and net to the health center (below). Month 1 nets -\$4,691; the first positive month is M2; from M17 the line holds at \$57,944 net per month.

¹⁹ CoachCare Value Analysis, 24-month forecast: monthly net reimbursement, fees and net-to-health-center series; Year 1 margin 41.56%, Year 2 margin 42.82%, 24-month margin 42.39%, each defined as net to the health center divided by net reimbursement. Ancillary fees of \$61,417 over 24 months: implementation, the eClinicalWorks integration (\$4,000 setup, \$150 a month and \$1.50 per patient-month) and telephonic outreach.

The shape of the curve is worth reading precisely. Month 1 is negative, -\$4,691, because implementation and enrollment effort land before the first full billing months do. Month 2 turns positive at \$5,307, month 3 nets \$10,226, and the line climbs as the three programs fill through the first year. M16, the month remote monitoring reaches its ceiling, is the peak at \$136,051 of net reimbursement and \$58,232 net; from M17 the line settles at \$135,478 of net reimbursement, \$77,534 of fees and \$57,944 net a month once the census holds at ceiling.

4.2 Program economics by year

Program	Year 1 net reimbursement	Year 2 net reimbursement	24-month net reimbursement	24-month CoachCare fees	24-month net to the health center
RPM	\$335,995	\$846,361	\$1,182,356	\$677,990	\$504,366
CCM	\$310,130	\$524,285	\$834,415	\$425,236	\$409,179
APCM	\$183,867	\$236,003	\$419,870	\$239,050	\$180,820
Ancillary (implementation, integration, outreach)	—	—	—	\$61,417	-\$61,417
All programs	\$829,992	\$1,606,649	\$2,436,642	\$1,403,693	\$1,032,948

CoachCare Value Analysis, per-program economics by contract year. Ancillary items: implementation, the eClinicalWorks integration (catalog tier: \$4,000 setup, \$150 a month and \$1.50 per patient-month) and telephonic outreach.

Program	Year 1 fees	Year 1 net	Year 2 fees	Year 2 net
RPM	\$188,559	\$147,436	\$489,431	\$356,930
CCM	\$158,049	\$152,081	\$267,187	\$257,098
APCM	\$104,683	\$79,184	\$134,367	\$101,637

Per-program fees and net to the health center by contract year, before ancillary items.

RPM is the volume engine at 12,108 patient-months and \$1,182,356 of net reimbursement. CCM is the yield engine at \$110.75 of net reimbursement per patient-month across 7,534 patient-months, against \$97.65 for RPM and \$56.96 for APCM over its 7,372. APCM earns its place a different way, as Section 3.2 sets out: no minute-tracking, a bundled monthly payment, and the level-3 tier on a panel where a third of the Medicare patients are dually eligible. Year 2 outruns Year 1 by \$776,657 of net reimbursement because Year 1 carries the ramp and Year 2 runs all three programs at ceiling from its first month.

Service-Line Composition: RPM \$1,182,356 · CCM \$834,415 · APCM \$419,870

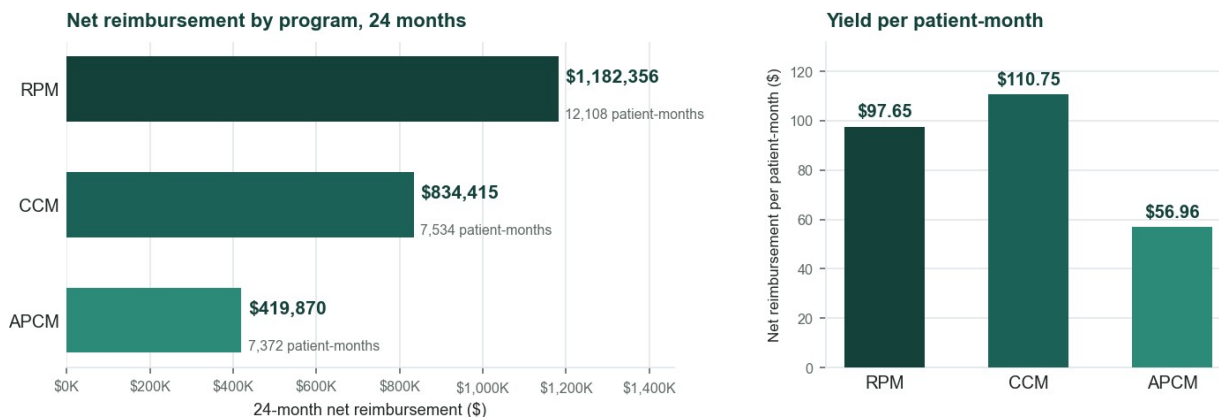


Figure 2. Service-line composition: per-program 24-month net reimbursement and net reimbursement per patient-month.

4.3 The ramp: pace-limited in year one

Say the constraint out loud: what binds this program in year one is enrollment pace, not the eligibility ceiling and not clinician count. The panel is large enough that the program keeps filling through the first year. Advanced primary care management reaches its ceiling of 345 enrollments in month 6, chronic care management its 394 in month 10, and remote monitoring its 748 in month 16.²⁰ The first 90 days move fast: 64 new enrollments across the three programs in month 1, 106 in month 2, 148 in month 3.

Program	Eligible pool	Ceiling	Ceiling reached	Active enrollments at M24
RPM	2,137	748	Month 16	748
CCM	1,315	394	Month 10	394
APCM	1,151	345	Month 6	345
All programs				1,488 enrollments · 970 unique patients

Enrollment counts are program enrollments, not unique patients; the 1,488 enrollments at M24 belong to 970 unique patients (1,310 enrollments across 792 patients at M12, still ramping), because a patient may carry a monitoring enrollment and a care-management enrollment at the same time.

That the constraint is pace, not the ceiling, cuts two ways. It means year one is a build, not a plateau, and it means the levers that matter are the ones that set enrollment speed. Three things move the program: the CoachCare-funded on-site enrollment specialist, which reaches every ceiling months sooner and is worth \$416,939 of 24-month net reimbursement against the no-specialist case; the referral engagement of the twenty-clinician bench; and the Medicare payer reconciliation, which sets how much of the panel is billable with certainty. Section 11 prices each of them.

4.4 What the program produces

24-month output	Volume
Claims generated, billing-ready	38,044

²⁰ CoachCare Value Analysis enrollment model: program ceilings 748 (RPM), 394 (CCM), 345 (APCM); ceilings reached in months 16, 10 and 6; 1,488 active enrollments across 970 unique patients at month 24 (1,310 enrollments across 792 patients at month 12, still ramping). Dedup: the care-management enrollments plus the RPM enrollments not already carrying a wrapper.

24-month output	Volume
Device readings monitored	127,137
Care-management tasks completed	76,089
Chart updates written to eClinicalWorks	19,022
Patient conversations held	11,413 (634 hours of call time)
Care-team hours delivered	16,444 (≈ 7.9 FTE-years)
Hospitalizations avoided	80.7 · ≈ \$1,210,500 at \$15,000 per admission

CoachCare Value Analysis operational and clinical outputs, 24 months.

The avoided-admission line deserves its own sentence. 80.7 avoided hospitalizations over 24 months is roughly \$1,210,500 of cost that never lands on anyone: not on Medicare, not on the Advantage plans that cover most of the county's Medicare, and not on a bed in a Middle Georgia hospital.²¹ It is also the entry requirement for every accountable-care arrangement: a consented, documented, monthly-managed panel with continuous readings, which this service line builds under fee-for-service first.

5. eClinicalWorks Integration: The Program Lives in the Record

The health center runs on eClinicalWorks, and the forecast prices CoachCare's eClinicalWorks integration at the catalog tier: \$4,000 setup, \$150 a month and \$1.50 per patient-month.²² The program operates inside the record rather than beside it. CoachCare's integration uses the workflows already in eClinicalWorks, so the health center's clinicians and billing staff learn no new system. The exact product edition and hosting are confirmed in contracting.

- **Out of the chart: enrollment flags and orders.** Qualifying patients are flagged and orders triggered inside the eClinicalWorks workflow; CoachCare enrolls flagged Medicare patients on the health center's behalf, and clinicians see enrollment status in real time in the chart they already use.
- **Back into the chart: vitals, documentation and status.** Device readings land as integrated vital reports; care plans, the care summary and enrollment status attach to the chart monthly; time capture writes back to the record.
- **Automated claims into eClinicalWorks billing.** The CoachCare billing engine creates the monthly claim lines automatically on the eClinicalWorks billing side, the step that makes individual-code billing workable at 38,044 claims over 24 months. The health center's own billing team files the FQHC claims with the care-management codes.
- **The discharge feed.** Hospital discharges reach the program from the record, which arms the post-discharge cadence in Section 6.5 without anyone relaying a message; the interface from each Middle Georgia hospital is an integration-scope item.

²¹ CoachCare Value Analysis clinical-outcomes module: 80.7 avoided hospitalizations over 24 months, valued at \$15,000 per avoided admission (≈\$1,210,500).

²² EHR as evidenced by the health center's patient-portal link (eClinicalWorks), September 2026; CoachCare integration pricing for eClinicalWorks as carried in the Value Analysis: \$4,000 setup, \$150 a month, \$1.50 per patient-month. The exact product edition and hosting are confirmed in contracting.

6. Clinical Governance and Escalation

6.1 A monitoring program is a clinical operation first

A monitoring program is a clinical operation before it is a revenue line. This section sets out the machinery the health center inherits on the first day of the program: CoachCare's Care Management Programs standard operating procedures, rendered as process maps covering qualification, monitoring, escalation and discharge.²³ The purpose is keeping a patient with heart failure or uncontrolled diabetes at home in Macon or Warner Robins, managed by their own care team, rather than in a hospital bed.

6.2 One shared escalation engine

Every program, RPM and the care-management wrappers alike, routes through one alert-and-escalation decision logic. A critical value escalates immediately, regardless of symptoms. An out-of-range reading that is not critical gets worked before it escalates: the patient retakes the reading and answers a symptom check, so the clinic hears clinical signal rather than cuff artifacts. Trend rules are explicit. Three consecutive out-of-range blood-pressure or glucose readings at least an hour apart, or three abnormal heart-rate readings inside seven days, count as a trend and draw clinical review even when no single reading is critical.

6.3 The emergent pathway

An active emergent symptom reported during any outreach contact triggers the 911 pathway. That policy supersedes any site-specific escalation preference: whichever of the eight sites the patient belongs to, whichever day of the week it is, the emergent floor does not move.

6.4 Qualification, device assignment and routing

Enrollment starts with the panel, not the device inventory. The population is screened by ICD-10 code and routed to the right program and device, and device assignment follows a fixed, ordered hierarchy in which the highest-priority qualifying diagnosis wins: a patient with heart failure and diabetes gets the device the higher-acuity condition needs. Once monitoring runs, escalations route three ways: emergencies to the emergent pathway, non-critical clinical items to the clinic for direction, and informational items documented to the chart.

6.5 The post-discharge cadence

A hospitalization within the last 60 days fires a fixed three-touch follow-up sequence: a first contact on day 1 or 2, a second on days 5 to 8, and a third on days 12 to 14. Each touch is documented, and any clinical alert surfaced during a touch escalates under the same shared logic; the post-discharge window gets more contact, not a different rulebook. For a discharge from a Middle Georgia hospital the first touch is also the interactive contact a transitional care episode requires, and the day-12-to-14 touch lands inside the 14-day visit window. One workflow serves both, and it is where most of the 80.7 avoided hospitalizations in Section 4.4 are won.

6.6 Discharge governance and continuity

Discharge from the program is governed, not ad hoc. Discharge criteria and unreachable-patient timelines are defined per program, and the clinic is notified in every case. For monitoring patients the sequence is explicit: a recommended discharge first escalates to the clinic for instructions, re-escalates every 30 days, and if the clinic has given no instruction by 180 days the discharge proceeds. Processed discharges post

²³ CoachCare Care Management Programs standard operating procedures and the derived process maps: qualification and device assignment; the RPM patient lifecycle; the care-management lifecycle; alert-and-escalation decision logic; the emergent and urgent communication protocol; the post-discharge follow-up sequence; and the discharge decision flow.

in the first week of the following month. Nobody quietly falls out of the program, and nobody quietly stays in it either.

7. Built for First Choice: Access and Operational Design

A remote care program for a panel that is 95% at or below the poverty line has to be built for access, not adapted to it afterward. The device, the outreach and the enrollment list all assume the patient First Choice actually serves. Six design decisions follow.

- **Cellular devices, not app-dependent.** A cellular cuff or glucose meter transmits the moment it is used: nothing to pair, no smartphone, no app, no password, no home broadband. For a panel where many households do not carry a smartphone or a data plan, that is the difference between a reading and a device in a drawer.
- **A monthly documented touch that reaches patients an office schedule does not.** For a patient two bus transfers from the clinic, a monthly call in their own language is the contact that catches a rising blood pressure or a missed refill. The between-visit touch is the program's clinical core and its billing basis at the same time.
- **Enrollment across eight sites and the school-based clinics.** The on-site enrollment specialist works where patients already come: the Macon and Warner Robins sites and the school-based clinics, so enrollment happens at a visit the patient was already making rather than a trip they have to add.
- **Enrollment lists pulled by condition, not by age.** The lists come from the hypertension, diabetes, heart-failure and COPD registries, screened by ICD-10 code per the qualification map, with payer attached so the traditional-Medicare and Medicare-Advantage patients are distinguishable from the first list.
- **Medication adherence paired with the two on-site 340B pharmacies.** The health center fills prescriptions in its own pharmacies in Macon and Warner Robins. Pairing the refill record with RPM readings closes the loop a monitoring program depends on: a blood pressure that will not come down because the medication is not being taken is a different problem from one that needs a titration, and the program can tell them apart.
- **Referrals from the whole adult-medicine floor.** Twenty adult-medicine clinicians, most of them nurse practitioners and physician assistants, flag patients in the chart. The flag is the whole clinician workflow; the program carries everything after it.

8. Market Context: Middle Georgia Medicare

Macon and Bibb County are a designated Medically Underserved Area, and Georgia did not expand Medicaid, so the safety net carries a heavy uninsured burden and every billable Medicare patient is worth more to a health center's budget.²⁴ The market fact that shapes this program most is the payer split. Bibb County's Medicare population runs near 61% Medicare Advantage, so the traditional Medicare panel a health center bills at the national rail with the least contract friction is a minority of an already minority Medicare base, and the dual-eligible patients are the population the APCM top tier was written for.²⁵

Middle Georgia Medicare	Value
Macon / Bibb County	Designated Medically Underserved Area
Medicare Advantage penetration, Macon / Bibb	~61%
Dually eligible share of the Medicare panel	31.9% (1,048 of 3,288)

²⁴ HRSA Medically Underserved Area designation for Macon and Bibb County; Georgia is a Medicaid non-expansion state, which sustains a heavy uninsured and sliding-fee burden at health centers.

²⁵ CMS Medicare Advantage State/County Penetration: Bibb County Medicare Advantage penetration near 61% (secondary source; confirm against CMS and the health center's own panel).

Middle Georgia Medicare	Value
Medicare patients in the health center's panel	3,288
Panel at or below the federal poverty guideline	94.9%
Georgia Medicaid	Non-expansion state

HRSA Uniform Data System 2025 (panel, poverty, dual count); CMS Medicare Advantage State/County Penetration (Bibb County); HRSA Medically Underserved Area designation.

These figures use the national amounts Medicare pays a health center. Medicare Advantage plans, which cover most of the Medicare panel in this market, reimburse the care-management and remote-monitoring families at a floor at least equal to the Medicare amount; individual plan contracts set their own terms. The conservative floor, counting only traditional Medicare, is \$1,126,144 of 24-month net reimbursement and \$471,036 net to the health center, on roughly 1,282 patients; the full-panel figure assumes Medicare Advantage parity across the book. That traditional-only line is the conservative floor; the full-panel figure is the working case, and the reconciliation that sits between them is the first discovery item.

9. The CY2027 Proposed Rule, Repriced on This Forecast

CMS published its proposed CY2027 physician fee schedule in July 2026. Comments on CMS-1848-P closed September 14, 2026; the final rule arrives in early November; the changes take effect January 1, 2027, and the statutory phase-in caps how far any code's payment can fall in a single year. The proposal that matters here is a reduction to the remote-monitoring device-supply codes. Every code in this forecast was repriced at the national amounts on this account's own billing mix, with enrollment held constant; the forecast's basis and the repricing table use the same national amounts on both sides.²⁶

The cascade: one code, one arm, one line

Device supply, 99454 and 99445: \$52.11 → \$41.38 a month, -20.6%. The code CMS proposes to cut.

The remote-monitoring arm: \$1,182,356 over 24 months, -9.5%, -\$112,498. Device supply is 32% of the remote-monitoring basket; management time moves little.

Chronic care management: \$834,415, -2.15%, -\$17,938. Advanced primary care management: \$419,870, -0.78%, -\$3,294. Conversion-factor and relative-value movement only; the proposal does not target these codes. The care-management movement is \$21,233 of the total.

The whole service line: \$2,436,642 over 24 months, -5.5%, -\$133,731, to \$2,302,910. Remote monitoring is 49% of the line, and two of the three programs are not the one being repriced.

²⁶ CMS-1848-P, proposed CY2027 Physician Fee Schedule (July 2026); comment period closed September 14, 2026. CoachCare repricing at the national non-facility amounts on this forecast's code frequencies and APCM tier weights: 99454 and 99445 from \$52.11 to \$41.38 (-20.6%); RPM arm -9.5% (-\$112,498); CCM -2.15% (-\$17,938); APCM -0.78% (-\$3,294); service line -5.5% (-\$133,731, from \$2,436,642 to \$2,302,910). Enrollment held constant; the statutory single-year phase-in caps how far a code's payment falls in one year.

The CY2027 Proposed Rule on This Forecast: One Code Cut, One Shared Dollar Scale

Device supply 99454 and 99445: \$52.11 → \$41.38 a month (~20.6%) · the RPM arm -9.5% · the line -5.5%, ~\$133,731 of \$2,436,642

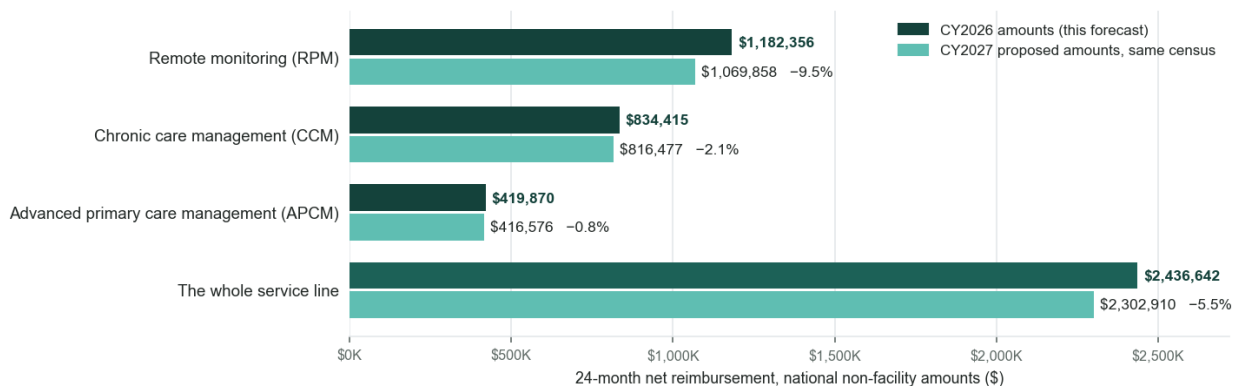


Figure 3. The CY2027 proposed rule on this forecast, at the national amounts on both sides: each arm and the whole line, CY2026 against the CY2027 proposed amounts, same census.

Two things hold the change in proportion. The proposal targets one code family, and the statutory phase-in caps a single year's reduction, so the full effect of the device-supply change does not land in CY2027 alone. The comment period has closed and the final rule is due in early November; this section is repriced then.

10. Implementation and the First 90 Days

10.1 Who runs what

CoachCare delivers	First Choice Primary Care keeps
Telephonic and on-site enrollment across the sites; the enrollment specialist is CoachCare's expense	Referral flags in eClinicalWorks; clinical oversight under general supervision
Cellular device logistics: supply, shipping, replacement	Sign-off on care plans, escalation preferences and the site-by-site routing
Monitoring, documentation and the escalation protocol of Section 6	Responses to clinic-routed escalations; the discharge feed from each hospital
Automated claim creation on the eClinicalWorks billing side	Filing the FQHC claims with the care-management codes; billing review; the revenue
Monthly operating reports against the dashboard in 10.3	Program governance; the enabling-services relationship with patients

10.2 Model inputs

Input	Value
Medicare panel in scope	3,288 patients, the health center's UDS 2025 Medicare count; reconciled by traditional-versus-Advantage split in the first 30 days
Referring clinicians	20 adult-medicine clinicians, a conservative subset of roughly 29 medical providers; behavioral, pediatric, school-based and women's-health-only clinicians excluded
Programs	RPM + CCM + APCM; TCM and BHI named, not in the forecast; PCM off
Program-eligible pools	RPM 2,137 · CCM 1,315 · APCM 1,151
Enrollment ceilings	RPM 748 (M16) · CCM 394 (M10) · APCM 345 (M6)
Acceptance	RPM 35% · CCM and APCM 30% of the eligible pool

Input	Value
Enrollment engine	8 referrals per clinician per month at 80% acceptance; one CoachCare-funded on-site enrollment specialist at 80 enrollments a month; telephonic outreach on; 1.5% monthly attrition
Rate basis	CY2026 national non-facility Physician Fee Schedule amounts, the rail a health center bills care-management codes on
APCM tier blend	15% level 1 · 64% level 2 · 21% level 3 = \$61.49 per patient-month
Medicare Advantage	Near 61% of Bibb County's Medicare. Medicare Advantage plans, which cover most of the Medicare panel in this market, reimburse the care-management and remote-monitoring families at a floor at least equal to the Medicare amount; individual plan contracts set their own terms.
EMR	eClinicalWorks, priced at the catalog integration tier (\$4,000 setup, \$150 a month, \$1.50 per patient-month)

10.3 The 90-day plan and the operating dashboard

Days 0–30: foundation. Program agreement and the eClinicalWorks integration workplan. The Medicare payer reconciliation, the traditional-versus-Advantage split of the 3,288, and the hypertension and diabetes registries by payer, the inputs that move the model most. ICD-10 screening of the Medicare panel per the qualification map, device logistics staged, escalation routing set across the eight sites, and clinician orientation to the general-supervision workflow.

Days 31–60: enrollment live. Telephonic and in-clinic enrollment running across the sites; first devices in homes; first billable service months. Month 1 nets –\$4,691 as implementation lands; month 2 turns positive. The forecast carries 64 new enrollments in month 1 and 106 in month 2.

Days 61–90: scale and file. 148 new enrollments in month 3, APCM approaching its ceiling. First monthly operating report against the dashboard, and the first read on referral pace against the twenty-clinician bench.

The operating dashboard from month one:

- Enrollment census by program against ceiling (748 / 394 / 345)
- Time from referral flag to first billable enrollment
- Discharges captured: hospital discharges that entered the three-touch cadence
- Device-reading days per patient-month against the 16-day 99454 threshold, with 99445 capturing 2- to 15-day months
- Escalations by pathway: emergent, clinic-routed, documented
- Claims generated against expected claims, and claims filed on the FQHC claim
- Blood-pressure control and A1c control among enrolled patients, against the UDS 2025 baseline of 62.61% and 24.56%
- Net to the health center per month against the \$57,944 steady-state line

11. Recommendations

1. **Stand up the Medicare service line now.** The individual-code rail has been live since October 2025. This is a \$1,032,948 two-year net line that funds itself from the second month; each month of delay pushes the ramp one month further out, and nothing about it waits on a hire.
2. **Reconcile the panel by payer in the first 30 days.** The 3,288-patient figure is the health center's own UDS count. In a market near 61% Medicare Advantage, the traditional-versus-Advantage split is the single largest thing to confirm: the traditional floor is \$1,126,144 of net reimbursement on

roughly 1,282 patients, the full-panel figure assumes Advantage parity, and the working case sits between them.

3. **Lead APCM with the dual-eligible patients.** A third of the Medicare patients are dually eligible, and G0558 at \$117.24 a month is the best-paying monthly code on the page. Set the wrapper rule at enrollment so dual-eligible patients with two or more conditions and Qualified Medicare Beneficiary status land on APCM level 3.
4. **Keep the CoachCare-funded enrollment specialist in the plan.** The specialist reaches every ceiling months sooner and is worth \$416,939 of 24-month net reimbursement against the no-specialist case in the table below; without it, remote monitoring does not fill until month 24. A second specialist adds a further \$193,213 and reaches the ceiling by month 12.
5. **Build the program for access from the first day.** Cellular devices, a monthly documented touch, enrollment across the eight sites and the schools, condition-based lists, and medication adherence paired with the two on-site pharmacies. None of these is a retrofit.
6. **Make the hospital discharge a front door.** Wire the discharge feed from the Middle Georgia hospitals, enroll at the first post-discharge contact, and bill transitional care on every discharge home to a health-center patient. TCM is in the forecast at zero dollars; every episode billed is upside, and every episode enrolled is a monitoring patient from the day they most need it.
7. **Set the attribution rule at enrollment.** Each patient carries one care-management wrapper, CCM or APCM, never both in a month, plus RPM where indicated and a transitional care episode after a discharge. One rule, set once in the enrollment workflow, prevents every double-billing collision the code families allow.

What moves the number

Scenario	24-month net reimbursement	Net to the health center	Margin	Ceiling reached RPM / CCM / APCM
Base: 3,288 panel, 20 clinicians, 1 enrollment specialist	\$2,436,642	\$1,032,948	42.39%	M16 / M10 / M6
No on-site enrollment specialist	\$2,019,703	\$856,000	42.38%	M24 / M15 / M8
Second on-site enrollment specialist	\$2,629,855	\$1,114,780	42.39%	M12 / M8 / M5
14 referring clinicians	\$2,258,848	\$958,101	42.42%	M20 / M12 / M6
29 referring clinicians (all medical providers)	\$2,601,516	\$1,102,483	42.38%	M13 / M8 / M5
Traditional Medicare only (~1,282; the Advantage-floor case)	\$1,126,144	\$471,036	41.83%	M7 / M5 / M3
Panel 2,949 (patients aged 65 and over only)	\$2,254,403	\$954,549	42.34%	M14 / M9 / M5

CoachCare Value Analysis recalculations at the same pricing. The binding constraint in year one is enrollment pace, not the eligibility ceiling; the enrollment specialist and the clinician count change when each ceiling is reached, the panel and the payer split change how large it is.

Read the table as two kinds of rows. The specialist and clinician rows move the timing, how fast the ceilings are reached, while the margin barely moves. The panel rows move the size: the traditional-Medicare floor is the conservative case pending the payer reconciliation, and the 2,949 row scopes to the aged-65-and-over cohort alone. The panel is the health center's own number to confirm.²⁷

²⁷ CoachCare Value Analysis recalculations at the same pricing: no on-site enrollment specialist \$2,019,703 / \$856,000 / 42.38%; second specialist \$2,629,855 / \$1,114,780 / 42.39%; 14 clinicians \$2,258,848 / \$958,101 / 42.42%; 29 clinicians \$2,601,516 / \$1,102,483 / 42.38%; traditional Medicare only (~1,282) \$1,126,144 / \$471,036 / 41.83%; panel 2,949 (aged 65 and over) \$2,254,403 / \$954,549 / 42.34%. The specialist is worth \$416,939 of 24-month net reimbursement against the no-specialist case.

12. The Ask: A Working Session

CoachCare asks for one working session with the health center's executive team, clinical leadership and billing lead. The forecast stands on the figures in Section 4; the session is about the four inputs that would move it, in the order they matter.

1. **The Medicare payer reconciliation.** The traditional-versus-Advantage split of the 3,288 Medicare patients, and which Advantage and dual-eligible plans the panel carries. In a market near 61% Advantage, this one split sets how much of the forecast bills at the Medicare floor with certainty.
2. **The hypertension and diabetes registries by payer.** 5,410 and 2,671 patients respectively; the Medicare slice sizes the RPM cohort in this forecast, and the split by traditional Medicare and Advantage sharpens the panel number.
3. **The current care-team roster.** Who on the current staff carries enabling-services, nursing and care-coordination work, and which of the adult-medicine clinicians are the active referrers.
4. **The eClinicalWorks product line and interfaces.** Which eClinicalWorks edition and billing setup the health center runs and which interfaces are available, so the integration workplan can be written.

Everything else in this report, the Medicare Advantage contract terms, the discharge feed from each Middle Georgia hospital, and the question of a Georgia Medicaid remote-monitoring line, is a workplan item that follows the session rather than a condition of it.

To arrange the session

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About CoachCare

CoachCare runs remote care programs for health centers, specialty practices and health systems: the enrollment, the devices, the clinical monitoring, the documentation and the claims, inside the EHR the organization already uses.²⁸

Measure	CoachCare, 2026
Patients managed	over 400 managed conditions for 500,000+ patients
Clinicians on the platform	10,000+ providers running remote care programs day to day
Implementations	1,000+ programs stood up and running in market
Claims generated	care-plan coding and billing behind more than 5 million claims
Vitals recorded	over 100 million vitals recorded; 4 million+ care actions enabled

References and Data Sources

- **HRSA Health Center Program records:** the Uniform Data System report for First Choice Primary Care (reporting years 2021–2025, 2025 the latest; total patients, payer counts, the dual-eligible count, the poverty share and the clinical quality measures) and the Health Center Program Section 330 grantee record (Community Health Center and Health Care for the Homeless funding streams).

²⁸ CoachCare company statistics, 2026: patients served, managed conditions, providers on the platform, implementations completed, claims generated and vitals recorded.

- **CMS Federally Qualified Health Center enrollment records:** the health center's organization National Provider Identifier and Medicare-certified FQHC status; the corporation founded in 2007.
- **The health center's website,** retrieved September 2026: the services, locations, hours, telehealth, pharmacy and careers pages and the site's brand assets; the EHR (eClinicalWorks) as evidenced by the patient-portal link on the site.
- **CMS Advanced Primary Care Management materials:** the G0556, G0557 and G0558 definitions, with G0558 as the Qualified Medicare Beneficiary tier for a patient with two or more chronic conditions.
- **The CY2025 Physician Fee Schedule Final Rule and the CY2026 Final Rule:** retirement of G0511 on September 30, 2025; individual-code reporting for health-center care management from October 1, 2025; payment at national non-facility amounts in addition to the PPS encounter; advanced primary care management adopted for health-center payment; the CY2026 additions 99445 and 99470.
- **CY2026 Physician Fee Schedule rate files:** national non-facility amounts for the eleven forecast codes, the two transitional care codes and the behavioral health integration code, at the national conversion factor with no geographic adjustment.
- **CMS-1848-P, the proposed CY2027 Physician Fee Schedule (July 2026):** the proposed national non-facility amounts used in the Section 9 repricing; comment period closed September 14, 2026.
- **CMS Medicare Advantage State/County Penetration:** the Bibb County Medicare Advantage penetration near 61% used in the market and payer sections.
- **HRSA shortage-area and Medically Underserved Area records:** the Macon and Bibb County Medically Underserved Area designation.
- **CMS Hospital General Information:** the Middle Georgia acute-care hospitals the health center's patients use, referenced by region only; no hospital or system is named.
- **CoachCare Care Management Programs standard operating procedures** and the derived process maps: the shared alert-and-escalation decision logic, trend definitions, the emergent communication protocol, three-way routing, the post-discharge three-touch sequence and the discharge decision flow reproduced in Section 6.
- **CoachCare eClinicalWorks integration overview:** integrated ordering and enrollment, enrollment status in the clinical workflow, integrated vital reports, monthly care-plan and care-summary documents, and automated claim creation on the eClinicalWorks billing side.
- **CoachCare Value Analysis for First Choice Primary Care, 2026, and the CY2027 repricing of the same forecast:** every financial, enrollment, clinical-output and operational figure in Sections 2, 4, 9, 10 and 11, built on 3,288 Medicare patients in scope, 20 referring clinicians, one on-site enrollment specialist, and CY2026 national non-facility amounts for RPM, CCM and APCM.

How this report counts

Patients and program enrollments are different numbers. At M24 the program holds 1,488 active program enrollments, which are services, belonging to 970 unique patients, because a patient may carry a monitoring enrollment and a care-management enrollment at the same time. Wherever this report gives a patient count it says patients; wherever it gives an enrollment count it says enrollments.

The panel figure is the health center's own. The 3,288-patient figure is the Medicare count the health center reported to HRSA for 2025, Original Medicare and Medicare Advantage together. The first implementation step reconciles it by payer, the traditional-versus-Advantage split that sets how much of the forecast bills at the Medicare floor with certainty.

No individual is named anywhere in this report. Governance, leadership and clinician composition are described by count, role and organization only.